STATE OF NORTH DAKOTA

MARKET CONDUCT EXAMINATION REPORT

NORIDIAN MUTUAL INSURANCE COMPANY
4510 13TH AVENUE SW
FARGO, ND 58121-0001

As of December 31, 2001

By Representatives of the
North Dakota Insurance Department

October 28, 2002

STATE OF NORTH DAKOTA

DEPARTMENT OF INSURANCE

I, the undersigned, Commissioner of Insurance of the State of North Dakota, do hereby certify that I have compared the annexed copy of the Market Conduct Examination Report of the

Noridian Mutual Insurance Company
4510 13th Avenue SW
Fargo, ND 58121-0001

as of December 31, 2001, with the original on file in this Department and that the same is a correct transcript therefrom and of the whole of said original.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal at my office in the City of Bismarck, this _____ day of _____, 2002.

_____
Jim Poolman
Commissioner of Insurance

TABLE OF CONTENTS

Fargo, North Dakota
September 24, 2002

Honorable Jim Poolman
Commissioner
North Dakota Insurance Department
600 East Boulevard Avenue
Bismarck, ND 58505

Dear Commissioner Poolman:

Pursuant to your instructions and in accordance with N.D. Cent. Code ' 26.1-03-19.2 and the rules, regulations, and procedures established by the National Association of Insurance Commissioners (hereinafter referred to as the ANAIC@), a comprehensive market conduct examination has been made of the North Dakota business of:

Noridian Mutual Insurance Company
Fargo, North Dakota

at its home office located at 4510 13th Avenue SW, Fargo, North Dakota. A report thereon is submitted as follows:

INTRODUCTION

This examination was conducted by the North Dakota Insurance Department Market Conduct Examiner at the Company=s home office.

SCOPE OF EXAMINATION

This examination began on February 11, 2002, and the on-site portion was concluded June 2002 . It generally covered the time period from January 1, 2000, through December 31, 2001, together with consideration of prior or subsequent matters as deemed pertinent in the judgment of the examiner. The examination was conducted in accordance with N.D. Cent. Code '' 26.1-03-19.2, 26.1-03-19.3, and 26.1-03-19.4, and under rules and regulations prescribed by the National Association of Insurance Commissioners (NAIC) to verify the Company=s compliance with statutes and regulations relating to market conduct practices and to determine if operations were consistent with the public interest.

The major areas reviewed were:

1. Company operations/management.
2. Complaint handling.
3. Grievance procedures.
4. Marketing and sales.

5. Network adequacy.

6. Producer licensing.

7. Provider credentialing.

8. Policyholder service.

9. Quality assessment and improvement.

10. Underwriting and rating.

11. Utilization review.

12. Claims.

This is a report by text. Attention is directed to the comments, suggestions, and recommendations in the ASummary of Recommendations@ section of the report.

AREAS OF REVIEW

Company Operations/Management

The evaluation of standards in this business area is based on review of Company responses to information requests, questions, interviews, and presentations made to the examiner. This portion of the examination is designed to provide a view of what the Company is and how it operates. It is not based on sampling techniques. It is more concerned with structure. This review is not intended to duplicate financial examination review but is important in establishing an understanding of the examinee. Many troubled companies have become so because management has not been structured to adequately recognize and address the problems that arise.

Well-run companies' management generally has some processes that are similar in structure. While these processes vary in details and effectiveness from company to company, the absence of them or the ineffective application of them is often reflected in failure of the various standards tested throughout the examination. The processes usually include:

- A planning function where direction, policy, objectives, and goals are formulated;
- An execution or implementation of the planning function elements;
- A measurement function that considers the results of the planning and execution; and
- A reaction function that utilizes the results of measurement to take corrective action or to modify the process to develop more efficient and effective management of its operations.

Standard A-1 – The Company has an up-to-date, valid internal or external audit program.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-08-02(4))

Comments: The review methodology for this standard is generic. With respect to financial status,

this standard has a direct statutory requirement contained in N.D. Admin. Code Chapter 45-03-20. A company that has no internal audit function lacks the ready means to detect structural problems until after problems have occurred. A valid internal or external audit function and its use is a key indicator of competency of management which the Commissioner may consider in the review of an insurer.

Results: Pass

Observations: The examiners noted three different functional levels of auditing within the company. The first involves the way in which the Internal Audit Department conducts audits. The second involves the way in which the Internal Audit Department reports its findings to management. The third involves the way in which the company is audited externally.

First, the Company has an Internal Audit Department. The Internal Audit Department performs audits of operational areas based on a risk assessment approach. Upon completion of the audit, the division audited may provide the Internal Audit Department with Corrective Actions Plans detailing proposed solutions, including target implementation dates, for any problems or concerns discovered during the audit. The Corrective Action Plan is then used to monitor that Division's corrective progress. Upon completion of an audit of an operational area, the Internal Audit Department provides a Final Report to the management staff and to each member of the Audit Committee as well as the Chief Operating Officer.

Second, the Internal Audit Department gives a full report that summarizes all audits in progress or completed at each quarterly Audit Committee meeting. The Audit Committee consists of four members of the Board of Directors. The Chairman of the Board serves as an ex-officio member of all committees of the Board, including the Audit Committee. The Audit Committee reports to the Board of Directors on a quarterly basis.

Third, pursuant to N.D. Admin. Code Chapter 45-03-20, every insurer licensed in North Dakota must be audited annually by independent certified public accountants. Eide Bailly, L.L.P., performs this statutory audit of the Company using Statutory Accounting Practices (SAP) on an annual basis and reports its findings back to the Company.

The Company has a valid, up-to-date internal and external auditing program.

Recommendations: None

Standard A-2 – The Company has appropriate controls, safeguards, and procedures for protecting the integrity of computer information.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-36-12.4)

Comments: Review methodology for this standard is generic. This standard does not have a direct statutory requirement; however, the standard is inferred by the referenced statutes. Appropriate safeguards for protecting the integrity of the computer information are a public protection issue. Appropriate controls, safeguards, and procedures for protecting the integrity of computer files is an indicator of competency of management that the Commissioner may consider in the review of an insurer.

Results: Pass

Observations: The company maintains a high level of security for its information systems. The report under this standard is broken into three main areas. First, the examiners describe some

changes made from a prior financial report. Second, the examiners explain some of the standards that exist internally to deal with information security. Third, the examiners discuss some basic requirements for providers submitting information electronically.

First, as part of this exam, the examiners reviewed an Information Systems Controls Evaluation Review Report (hereinafter "ISCER Report") previously generated by Insurance Regulatory Services, Inc. (INS) on behalf of the North Dakota Insurance Department and incorporated into the financial examination report dated December 31, 1999. The ISCER Report covered the time period of January 1, 1999, through December 31, 1999. This time frame is outside the scope of this examination; however, the examiners reviewed this report to monitor progress.

In the Summary of Recommendations portion of the ISCER Report, INS recommended that "the company should institute effective policies and procedures to ensure that all change requests, authorizations, and approvals are appropriately documented by the appropriate level of management." The Company responded to this recommendation by generating a Corrective Action Plan (hereinafter "CAP") within the Information Services Division. This CAP was provided to the Internal Auditing Department so that the plan's implementation could be monitored.

Again, in the Summary of Recommendations portion of the ISCER Report, INS made a finding that physical access to information systems was not adequately monitored. Again, the Company responded to this recommendation by generating another CAP within the Information Services Division. This CAP was provided to the Internal Auditing Department so that the plan's implementation could be monitored.

Second, the company has some standards that exist internally to deal with information security. The Company maintains an Information Systems Standards and Procedural Manual on its intranet. The Standards and Procedural Manual sets forth various company standards for security of information. Some of those standards include (styled in the format of the manual):

7.2 Shop Security

7.2.1 Management
Standard: Data Processing (DP) management is responsible for the protection of computer hardware and software located within the DP Division and information stored within.

7.2.2 Supervisory
Standard: Employees in supervisory roles – such as Project Leaders, IPC Supervisors, or any other employee who supervises another employee(s) – are responsible for the education of staff members in the areas of security.

7.2.3 Data Processing Division Employees
Standard: Employees are expected to exercise good business sense as it relates to security.

7.2.4 Outside Vendor User Code Setup
All outside vendors must be required to go through the Data Security Administrator for usercode set up. An expiration date will be set for all outside vendors.

7.2.5 Destruction of Obsolete Equipment & Software
When a computer needs to be replaced the hard drive is completely erased and rebuilt. If the computer is nonfunctional it is destroyed. If the computer is in functional order it is given to a charity.

7.5 Sensitive Data
Standard: Through normal working conditions, individuals may come in contact with sensitive data concerning the company's business information. Discussion of the material with persons not having a "business need to know" is reason for termination.

Other standards further limit access by personnel to particular programs, and various data storage locations. The standards also set requirements for passwords. These standards provide security of information within the Company.

Third, there are some basic requirements for providers submitting information electronically. Providers may submit claims electronically; however, the Company has a protocol that is followed before a provider is allowed to submit claims in this manner. Each provider must have a system with certain minimum requirements. Located on the company website, http://www.bcbsnd.com, under the "Providers" link, EDI (Electronic Data Interchange) sub-link, EDI enrollment forms sub-link, there is a list of North Dakota lines of business. Within each of these links, there are documents maintained in an Adobe Acrobat PDF format that list various ways in which providers should handle claims data submissions.

The Company has appropriate controls, safeguards, and procedures for protecting the integrity of computer information.

Recommendations: None

Standard A-3 – The Company has an antifraud plan in place.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-02.1-02)

Comments: Review methodology for this standard is generic. This standard does not have a direct statutory requirement; however, the standard is inferred by the referenced statutes. Written procedural manuals or guides and antifraud plans should provide sufficient detail to enable employees to perform their functions in accordance with the goals and direction of management. Appropriate antifraud activity is important for asset protection as well as policyholder protection and is an indicator of competency of management which the Commissioner may consider in the review of an insurer. Further, the insurer has an affirmative responsibility to report fraudulent activities of which it becomes aware.

Results: Pass

Observations: The Company has established a Fraud Committee that meets monthly. The Fraud Committee is staffed by a multi-disciplinary group of employees. As employees all members of the Fraud Committee are available to consult on any fraud matter that needs immediate attention. The current Fraud Committee members as of the examination date were the Legal Counsel, Medical Director, Manager of Private Business Claims, Director of Reimbursement, a Compliance Officer, and a Compliance Specialist. The Fraud Committee reviews reports of potential fraud. The reports most typically are generated from the Fraud Hotline, Customer Service, Claims, Reimbursement areas, and occasionally the Medical Affairs area.

The Fraud Hotline is maintained in the Compliance Department by the Compliance Specialist. All calls to the Fraud Hotline are noted in a log book. The number for the Fraud Hotline is available on the website and included on all Explanation of Benefits. The Fraud Hotline also has a voice messaging system to record messages when the Compliance Specialist is not available.

Recommendations: The Company should develop a formal Anti-fraud Plan. The Anti-fraud Plan should be reduced to writing. The Anti-fraud Plan should include, but not be limited to, a set of standards/guidelines to address the resolution of all reports of potential fraud. The Anti-fraud Plan should also establish the authority of the Fraud Committee.

Standard A-4 – The Company has a valid disaster recovery plan.
(NDCC §§ 26.1-02-03, 26.1-03-19.2)

Comments: Review methodology for this standard is generic. This standard does not have a direct statutory requirement; however, the standard is inferred by the referenced statutes. It is essential that the Company have a formalized disaster recovery plan that will detail procedures for continuing operations in the event of any type of disaster. Appropriate disaster recovery planning is an indicator of competency of management which the Commissioner may consider in the review of an insurer.

Results: Pass

Observations: This report explains first, the type of disaster recovery plan in place for the company. Second, it discusses the use of this disaster recovery plan in response to a specific disaster. Finally, it addresses some changes made to the disaster recovery plan in response to that same disaster.

First, the Company has a comprehensive disaster recovery plan known as their Business Contingency and Continuity Plan (BCCP). As a Medicare contractor, the Company is required to complete the Contractor Assessment Security Tool (CAST) and the Triennial Risk Assessment (TRA). The CAST is an annual self-assessment of detailed systems security requirements, including 68 requirements for service continuity. The TRA is an analysis designed to identify specific risks and the corresponding safeguards to mitigate those risks, including risks associated with disaster and disruption. The TRA must be reviewed annually for major changes and updated appropriately. Information Services Department performs a disaster recovery test of the mainframe each year.

Second, the disaster recovery plan was implemented in June 2000 when the first floor of the Company's home office flooded. At the time much of the Company's information systems and communication systems wiring was on the first floor of the home office. The Company was able to maintain its computer operations with only a minimal impact on the business process.

In response to the flood, the Company built its Critical Systems Operation Center (CSOC) in a building adjacent to the home office. The CSOC was constructed to provide a secure, reliable environment for IT systems, telecommunications systems, and production mail. The structure of the CSOC was built to withstand many natural and man-made disasters. In addition to the CSOC, the Company has two hot sites where they can be fully operational in case a disaster hits the CSOC. One hot site is in Fargo several miles from the CSOC and the second hot site is at IBM in Sterling Forest, New York.

A copy of the BCCP is maintained at each of the hot sites. The Company backs up all computer systems to tape each night. The back-up tapes are maintained in the vault of a storage building on the other side of Fargo from the CSOC.

The Company has a valid disaster recovery plan.

Recommendations: None

Standard A-5 – The Company adequately monitors the activities of the MGA.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-02.1-02)

Comments: Review methodology for this standard is generic. This standard has a direct insurance statutory requirement. This standard is focused on the level of the oversight provided by the Company when it contracts with an external entity that assumes a business function of the Company. The particular interest is on oversight impacting records and actions considered in a market conduct examination such as, but not limited to, trade practices, claim practices, policy selection and issuance, rating, complaint handling, etc.

Results: Pass

Observations: The Company has a third-party administrator service contract with Prime Therapeutics, Inc. (PTI) to provide pharmacy services to members. PTI handles the claims on behalf of the Company and works with pharmacies regarding claims submissions. Claims checks are paid by PTI directly to the pharmacy provider. PTI provides the Company with a Statement of Account (invoice) on a weekly basis detailing the amount due to each pharmacy. The Company then wires PTI the amount due per the Statement of Account via a clearinghouse.

Additionally, PTI provides a formulary service to the Company. This formulary service is the development and management of a formulary drug and medication list. A formulary drug is a brand name or generic prescription medication or drug for which the Company provides maximum payment levels. The formulary is a list of formulary drugs selected on the basis of safety, therapeutically effectiveness, high quality, and cost as determined by a committee of physicians and pharmacists. The Pharmacy and Therapeutics (P&T) Committee reviews the formulary quarterly.

The Company has a third-party administrator (TPA) contract with Benefit Plan Administrators (BPA). BPA is an indirectly wholly-owned subsidiary of the Company. BPA was acquired by the Company's subsidiary, Coordinated Insurance Services, Inc. (CISI) in 1995. CISI's name has changed and is now known as Noridian Insurance Services. BPA provides administrative services to its customers. BPA is subject to audits by Eide Bailly, L.L.P., the Company's CPA, and BPA is also subject to audits by the Internal Audit Department.

The Company has contracted with agents and managing general agents (MGA). The primary function of the agents and MGA is writing business by accepting applications. All other functions, including underwriting and rating, are done by the Company.

Recommendations: None

Standard A-6 – Company contracts with MGAs comply with applicable statutes, rules, and regulations.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-03)

Comments: Review methodology for this standard is generic. This standard has a direct insurance statutory requirement. This standard is concerned with the contract between the Company and an external entity when the Company contracts with an external entity to assume a business function of the Company. The aim of this standard is to assure that a Company using such an external entity does so with realistic contractual provisions. The focus is on the contractual provisions impacting records and actions considered in a market conduct examination such as, but not limited

to, trade practices, claim practices, policy selection and issuance, rating, complaint handling, etc. as set forth in statute.

Results: Pass

Observations: As noted in the observations of Standard A-5, the Company has a formulary service (TPA) contract with Prime Therapeutics, Inc. (PTI) to provide services related to pharmacy to members on behalf of the Company. Claims checks are paid by PTI directly to the pharmacy provider. PTI is then reimbursed by the Company for these payments.

Again, the Company has a third-party administrator (TPA) contract with Benefit Plan Administrators (BPA). BPA is an indirectly wholly-owned subsidiary of the Company. BPA was acquired by the Company's subsidiary, Coordinated Insurance Services, Inc. (CISI) in 1995. CISI's name has since changed and is now known as Noridian Insurance Services. BPA provides administrative services to its customers. BPA is subject to audits by Eide Bailly, L.L.P., the Company's CPA, and BPA is also subject to audits by the Internal Audit Department.

Again, as noted in Standard A-5, the Company has contracted with agents and managing general agents (MGAs). The primary function of the agents and MGAs is writing business by accepting applications. The Company performs all other functions, including underwriting and rating.

Lastly, North Dakota requires contracts with MGAs/TPAs to be pre-approved. The examiners did not note any MGA/TPA contracts that were not pre-approved.

Recommendations: None

***Standard A*-7 – Records are adequate, accessible, consistent, and orderly and comply with North Dakota record retention requirements.**
(NDCC §§ 26.1-02-03, 26.1-03-19.2)

Comments: Review methodology for this standard is generic. This standard does not have a direct statutory requirement; however, the standard is inferred by the referenced statutes. This standard is intended to assure that an adequate and accessible record exists of the company's transactions. The focus is on the records and actions considered in a market conduct examination such as, but not limited to, trade practices, claim practices, policy selection and issuance, rating, complaint handling, etc. Inadequate, disorderly, inconsistent, and inaccessible records can lead to inappropriate handling of claims, inappropriate rates, and other issues which can provide harm to the public.

Results: Pass

Observations: The Company receives and tracks both correspondence and claims electronically within an intercompany system know as BOLTS. A claim or correspondence is maintained electronically until the claim or correspondence is inactive for a period of 18 months. Once the claim or correspondence reaches this level of inactivity, it is transferred to the Company's data warehouse. The claims or correspondence material are filmed onto microfiche and are maintained in the data warehouse indefinitely. The examiners requested various claims files using a sample method. Some of the claim files generated from the sampling techniques included files with 18 or more months of inactivity. Therefore, the Company was required to retrieve those claims files from the Company's data warehouse. The hard copies of those files were provided to the examiners without exception.

Recommendations: None

Standard A-8 – The Company is licensed for the lines of business that are being written.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-12-08, 26.1-12-27, 26.1-33-14)

Comments: Review methodology for this standard is generic. This standard has a direct insurance statutory requirement. This standard is intended to assure that the Company operations are in conformance with the Company's Certificate of Authority.

Results: Pass

Observations: The Company is licensed to sell health insurance in North Dakota, South Dakota, and Minnesota. The examiner reviewed all three Certificates of Authority provided by the Company and cross-referenced the North Dakota Certificate of Authority with the Certificate of Authority on file at the North Dakota Insurance Department. A review of the annual statements was also conducted to verify the source of the Company's premiums. All writings reviewed were found to be in accord with the Company's authority. No exceptions were noted.

Recommendations: None

Standard A-9 – The Company cooperates on a timely basis with examiners performing the examinations.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-03-19.3)

Comments: Review methodology for this standard is generic. This standard has a direct insurance statutory requirement. This standard is aimed at assuring that the Company is cooperating with the state in the completion of an open and cogent review of the Company's operations in North Dakota. Cooperation with examiners in the conduct of an examination is not only required by statute, it is conducive to completing the examination in a timely fashion and minimizing cost.

Results: Pass

Observations: The Company designated Suzanne Michelson, Planning Analyst, as a contact person for exam coordination. Ms. Michelson was well organized, prompt in response, and thorough. With few slight exceptions, the Company was able to provide the examiners with all of its requested information. In situations where specific information could not be provided, Ms. Michelson arranged meetings with various staff personnel to allow the examiners to discover what information was available to address the concerns of the State of North Dakota. Overall, the Company cooperation with the examiners was excellent.

Recommendations: None

Standard A-10 – The Company has procedures for the collection, use, and disclosure of information gathered in connection with insurance transactions to minimize any improper intrusion into the privacy of applicants and policyholders.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-36-12.4)

Comments: Review methodology for this standard is generic. This standard has a direct insurance statutory requirement. This standard is intended to assure that the Company provides adequate protection for information it holds concerning its policyholders and minimizes any improper intrusion

into the privacy of applicants and policyholders.

Results: Pass

Observations: Standards A-10 and A-2 are interrelated within this Company because of the way in which information is gathered. As noted earlier, the Company receives the majority of its claims electronically. Standard A-2 explained the way in which computer information is protected. Inclusive of that explanation is the Company's policy and procedure for the collection, use, and disclosure of sensitive data. As noted in the Observations section of Standard A-2, the Company has some standards that exist internally to deal with information security. The Company Information Systems Standards and Procedural Manual maintained on its intranet sets forth various company standards for security of information. One of those standards includes (styled in the format of the manual):

> 7.5 Sensitive Data
> **Standard:** Through normal working conditions, individuals may come in contact with sensitive data concerning the company's business information. Discussion of the material with persons not having a "business need to know" is reason for termination.

The Company has procedures for the collection, use, and disclosure of information gathered in connection with insurance transactions to minimize any improper intrusion into the privacy of applicants and policyholders.

Recommendations: None

Standard A-11 – The Company had developed and implemented written policies, standards, and procedures for the management of insurance information.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-36-12.4)

Comments: Review methodology for this standard is generic. This standard has a direct insurance statutory requirement. This standard is intended to assure that the Company provides adequate protection for information it holds concerning its policyholders and minimizes any improper intrusion into the privacy of applicants and policyholders.

Results: Pass

Observations: The concerns addressed in this standard are also partially addressed in Standards A-2 and A-10. A review of the observations for those standards may provide additional information for this standard.

Additionally, the Company has manuals that set forth the procedures that must be followed by the various areas (i.e., medical management, marketing, or member services) that obtain and verify personal information. The Company has an integrated system that requires adherence to the established procedure manuals. The system has levels of security for specific types of changes, and the system includes a safeguard that automatically generates the appropriate member letter to verify any changes made.

Recommendations: None

Standard A-12 – The Company adequately monitors the activities of vendors involved in policyholder services, underwriting, claims, or marketing.

(NDCC §§ 26.1-02-03, 26.1-03-19.2)

Comments: Review methodology for this standard is generic. This standard has a direct insurance statutory requirement. This standard is focused on the level of the oversight provided by the Company when it contracts with an external entity that assumes a business function of the Company. The particular interest is on oversight impacting records and actions considered in a market conduct examination such as, but not limited to, trade practices, claim practices, policy selection and issuance, rating, complaint handling, etc.

Results: Pass

Observations: The Company does not specifically audit individual vendors, and it is not clear from the vendor contracts whether functions performed solely by vendors may be audited by the Internal Audit Department of the Company. It is clear, however, that the Internal Audit Department of the Company performs procedure-based audits. Procedures performed by vendors (i.e., claims approval) are included in this population of reviewed transactions or materials. Therefore, procedures performed by the vendors may be reviewed during the internal audit of the Company but no direct audit of the vendor is conducted.

It should be noted that the Company handles all of its underwriting and rate making services internally and handles the majority of the remaining services listed in the above standard internally.

Recommendations: None

Complaint Handling

Evaluation of the standards in this business area is based on the Company's response to various information requests and complaint files at the Company. N.D. Cent. Code § 26.1-04-03(10) provides that the following is an unfair method of competition and an unfair and deceptive act or practice in the business of insurance: "Unfair handling of communications by insurance company. Failing to adopt and implement reasonable standards for the prompt handling of written communications, primarily expressing grievances, received by the insurance company from insureds or claimants."

Standard B-1 – All complaints or grievances are recorded in the required format on the Company complaint register.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-04-03(10))

Comments: Review methodology for this standard is generic. This standard is inferred by statute. This standard is concerned with whether the Company keeps formal track of complaints or grievances. An insurer should maintain a control record of all the complaints or grievances received.

Results: Pass

Observations: The Company monitors all correspondence through an internal computer system referred to as "correspondence control." Correspondence control tracks all inquiries, complaints, and grievances. The information that is tracked includes contract number, product, name, caller, home phone number, work phone number, received date, created date and time, completed date, service from and service through dates, type of business, member number, member name, group or

roll number, subject matter, physician number and name, provider number and name, and a listing of internal personnel handling the correspondence and their typewritten comments.

The tracked correspondence may be received from the North Dakota Insurance Department or may be received from an insured. The various methods of correspondence include telephone, mail, email, or walk-ins. The Company's website includes a "contact us" link that allows members to contact a division of the Company called "Member Services" to inquire about benefits, claims, and other policyholder information. The Summary Plan Description booklets provided to each insured contains a page listing contact telephone numbers and addresses, including a contact telephone number for Member Services. All of these methods of correspondence are tracked through correspondence control. The level of information maintained within correspondence control gave the examiners reassurance that inquiries, complaints, and grievances are properly recorded within the requirements of this standard.

Recommendations: None

Standard B-2 – The Company has adequate complaint/grievance handling procedures in place and communicates such procedures to policyholders.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-04-03(10))

Comments: Review methodology for this standard is generic. This standard has a direct insurance requirement. This standard is concerned with whether the Company has an adequate complaint handling procedure and whether the Company communicates complaint handling procedures to its members.

Results: Pass

Observations: All contacts by either the North Dakota Insurance Department or by a policyholder are tracked and routed electronically through an inquiry tracking system that was developed by the Company. Once the contact is initiated, it is routed to the appropriate Member Services personnel for review and response. All contacts are routed according to the nature of the contact. The contact may be considered an inquiry, grievance, complaint, or request for an appeal. If the nature of the contact is such that it can be responded to by an employee of the Member Services Division, that employee will respond. If additional research is necessary, the inquiry is forwarded to the appropriate employee and the date and time of forwarding is tracked in the inquiry tracking system.

Upon request, a policyholder is given a packet of information regarding the appeals and grievances process. A copy of this information was given to the examiners. The information packet distinguishes inquiries, complaints, grievances, and appeals. Each one is first defined generally and is then given an entire section explaining the concept to the insured. The appeals section explains the insured's right on appeal. Additionally, the Summary Plan Descriptions contain a section regarding appeals. The Summary Plan Description is given to every insured, and every Summary Plan Description contains the following language: "If [the Company] makes a determination that results in a reduction or denial of benefits, the Member and/or the Member's Health Care Provider may appeal the determination." The Summary Plan Description goes on to describe three types of appeals processes—Emergency Services, Preauthorization or Prior Approval, and Other Claims. The three types of appeals are explained in greater detail in the information packet that is made available to the policyholders.

The examiner is satisfied that the Company has adequate complaint and grievance handling procedures in place and communicates such procedures to the insured.

Recommendations: None

Standard B-3 – The Company takes adequate steps to finalize and dispose of the complaint/grievance in accordance with applicable statutes, rules, and regulations and contract language.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-04-03(10))

Comments: Review methodology for this standard is sample. This standard has a direct insurance statutory requirement. This standard is concerned with whether the Company deals with the subject matter in a complaint/grievance.

Results: Pass

Observations: A random sample of complaint files from the complaint logs for the examination period was requested for review by the examiners. The concern tested with this standard is that the disposition of the complaint file is appropriate.

Type	Sampled	Pass	Fail	% Pass
Complaints	50	50	0	100%

The original sample size was 50 complaint files. Within the original sample some complaints related to areas outside of the scope of this examination, including but not limited to, chiropractic services and dental services. The Company produced those complaint files; however, the examiners chose to forego review of those complaints and chose seven additional files at random to review in their place.

Recommendations: None

Standard B-4 – The time frame within which the Company responds to complaints/grievances is in accordance with applicable statutes, rules, and regulations.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-04-03(10))

Comments: Review methodology for this standard is sample. This standard has a direct insurance statutory requirement. This standard is concerned with whether the Company has a timely response to complaints/grievances.

Results: Pass

Observations: A random sample of complaint files from the complaint logs for the examination period was requested for review by the examiners. The concern tested with this standard is that the responses to the issues raised in the complaint file were timely.

Type	Sampled	Pass	Fail	% Pass
Complaints	50	50	0	100%

The original sample size was 50 complaint files. Within the original sample some complaints related to areas outside of the scope of this examination, including but not limited to, chiropractic services and dental services. The Company produced those complaint files; however, the

examiners chose to forego review of those complaints and chose seven additional files at random to review in their place.

Recommendations: None

Standard B-5 – Documentation of complaints is adequate and in accordance with applicable statutes, rules, and regulations.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-04-03(10))

Comments: Review methodology for this standard is sample. This standard does not have a direct insurance statutory requirement; however, documentation is inferred. This standard is concerned with whether the company has adequate documentation to demonstrate handling and disposition of the complaint.

Results: Pass

Observations: A random sample of complaint files from the complaint logs for the examination period was requested for review by the examiners. The concern tested with this standard is that the documentation of the complaint file is sufficient to demonstrate that there was appropriate disposition of the complaint.

Type	Sampled	Pass	Fail	% Pass
Complaints	50	50	0	100%

The original sample size was 50 complaint files. Within the original sample some complaints related to areas outside of the scope of this examination including, but not limited to, chiropractic services and dental services. The Company produced those complaint files; however, the examiners chose to forego review of those complaints and chose seven additional files at random to review in their place.

Recommendations: None

Grievance Procedures

Evaluation of the standards in this business area is based on the Company's response to various information requests and grievance files at the Company. N.D. Cent. Code § 26.1-04-03(10) provides that the following is an unfair method of competition and an unfair and deceptive act or practice in the business of insurance: "Unfair handling of communications by insurance company. Failing to adopt and implement reasonable standards for the prompt handling of written communications, primarily expressing grievances, received by the insurance company from insureds or claimants." Essentially, grievances reviewed or tested under this section are a subset of the Company's complaint system.

There exists a difference between the way in which the National Association of Insurance Commissioners (NAIC) defines a grievance and the way in which the Company defines a grievance. The NAIC defines a grievance as:

> A written complaint submitted by or on behalf of a covered person regarding the availability, delivery or quality of health services, including a complaint regarding an adverse determination made pursuant to utilization review; claims payment, handling or

reimbursement for health care services; or matters pertaining to the contractual relationship between a covered person and a health carrier.

The Company defines a grievance as:

> A complaint about the manner in which the patient or service had been handled. It relates not to the terms of the insurance or coverage, but in the fashion in which the care is provided by the health care provider (i.e., access to and availability of services, choice and accessibility or providers, quality of care, quality of service, conduct behavior, facility, and network adequacy).

This is not the only difference. There exists a slight discrepancy between the NAIC definition of a complaint and the Company's definition of a complaint. First off, it should be noted that the NAIC definition of a complaint is inclusive of its definition of a grievance. In other words, all grievances fit the definition of complaints. The NAIC definition of a complaint is:

> A written communication primarily expressing a grievance (meaning an expression of dissatisfaction).

The Company defines a complaint as:

> An expression of dissatisfaction that relates to terms of insurance or coverage (oral/written).

Given the discrepancies within the definitions, the examiners chose to review a sample of correspondence that is received and handled by the Company from either an insured, a provider, or the North Dakota Department of Insurance. It should be noted that the Inquiry Tracking System developed and used by the Company tracks inquiries, complaints, grievances, and appeals. The examiners reviewed a sample of files that were tracked by the Inquiry Tracking System. Those interactions of the Company, the inquiries complaints grievances, and requests for appeals were addressed in the B Standards. As such, the C Standards may not apply directly or may have been addressed within the B Standards.

Standard C-1 – The health carrier treats as a grievance any written complaint submitted by or on behalf of a covered person regarding (1) the availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; (2) claims payment, handling, or reimbursement for health care services; or (3) matters pertaining to the contractual relationship between a covered person and the carrier including items disclosed pursuant to N.D. Cent. Code § 26.1-36-03.1.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-04-03(10), 26.1-36-03.1)

Comments: Review methodology for this standard is sample. This standard does have a direct insurance statutory requirement. This standard is concerned with appropriate treatment of grievances received.

Results: Pass

Observations: A random sample of grievance files from the complaint logs for the examination period was requested for review by the examiners. The concern tested with this standard is hat the grievance is appropriately treated.

As noted earlier, every incoming source of correspondence is tracked by the Inquiry Tracking System and is routed to the appropriate department for handling. The Company differentiates between general inquiries, grievances, complaints, and requests for appeals. The crux of this standard when reviewed by the examiner is not that the Company terms any written complaint regarding the availability, delivery, or quality of service as a grievance; rather the crux is that such

correspondence is handled in a prompt and appropriate manner. Within the B Standards, the examiners reviewed a sample of complaints from the Inquiry Tracking System measuring timeliness, proper disposition, and documentation. The examiners were satisfied that the level of attention from the Company to any correspondence was commensurate with the characterization and level concern generated by the correspondence. This standard was, therefore, not reviewed directly through sampling. Rather, it was addressed indirectly through the B Standards sampling.

Recommendations: None

Standard C-2 – The health carrier documents grievances and establishes and maintains grievance procedures in compliance with statutes, rules, and regulations.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-04-03(10), 26.1-36-03.1)

Comments: Review methodology for this standard is sample. This standard does have a direct insurance statutory requirement. This standard is concerned with whether the company has adequate documentation to demonstrate handling and disposition of the grievance.

Results: Pass

Observations: A random sample of grievance files from the complaint logs for the examination period was requested for review by the examiners. The concern tested with this standard is that the documentation of the grievance file is sufficient.

Standards B-1 and B-3 both indirectly address this issue. The Company's Inquiry Tracking System tracks all internal and external communications regarding all correspondence with the Company. As such, this system creates a documentation trail regarding the various discussions and persons involved regarding any piece of correspondence. Additionally a hard file is maintained for those grievances that require additional documentation. Those files are eventually filmed onto microfiche. Therefore, the grievances are adequately documented. The Company's Grievance Handling System is in compliance with North Dakota statutes, rules, and regulations. Again, since this standard was addressed indirectly by the B Standards, it was not reviewed directly by sampling.

Recommendations: None

Standard C-3 – The Company files with the Commissioner a copy of its grievance procedures, including all forms used to process a grievance.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-04-03(10), 26.1-36-03.1)

Comments: Review methodology for this standard is generic. This standard does have a direct insurance statutory requirement. This standard is concerned with whether the company has filed its grievance process with the Commissioner.

Results: Pass

Observations: On April 6, 2000, the North Dakota Insurance Department received an Appeals and Grievances Manual from the Company for filing and approval. The Appeals and Grievances Manual was filed and approved on April 20, 2000. After reviewing the manual the examiners are satisfied that the Company has filed the appropriate documents with the North Dakota Insurance Department.

Recommendations: None

Standard C-4 – The health carrier conducts first level reviews of grievances in compliance with statutes, rules, and regulations.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-04-03(10), 26.1-36-03.1)

Comments: Review methodology for this standard is sample. This standard does have a direct insurance statutory requirement. This standard is concerned with whether the company conducts a first level review of a grievance.

Results: Pass

Observations: A random sample of grievance files from the complaint logs for the examination period was requested for review by the examiners. The concern tested with this standard is that first level review of grievances is in accord with statutory requirements.

During a review of the B Standards, the examiners were able to determine with reasonable certainty that the Company conducts first level reviews of grievances in compliance with statutes, rules, and regulations. All grievances are initially treated in the same manner as all correspondence. The Company receives the correspondence. The Company's Inquiry Tracking System tracks the correspondence as it is routed to the appropriate person within the Member Services Division. In routing the correspondence, the Company characterizes the correspondence as inquiry, complaint, grievance, or request for appeal. Once routed, if the person to whom it was routed is unable to resolve the dispute it is rerouted to other personnel for additional research and review. The Company has an internal standard that all inquiries are handled with 99% accuracy and that 90% of all inquiries are resolved within seven days.

Recommendations: None

Standard C-5 – The Company conducts second level reviews of grievances in accordance with statutes, rules, and regulations.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-04-03(10), 26.1-36-03.1)

Comments: Review methodology for this standard is sample. This standard does have a direct insurance statutory requirement. This standard is concerned with whether the company conducts second level reviews of grievances.

Results: Pass

Observations: A random sample of grievance files from the complaint logs for the examination period was requested for review by the examiners. The concern tested with this standard is that second level review of grievances is in accord with statutory requirements.

It is important to note again that the NAIC and the Company have different definitions for grievances. The Company handles all second level grievances, according to its own definition of grievance, by logging the grievance onto the correspondence control Inquiry Tracking System and routing the grievance to the Manager of Member Services. The Manager of Member Services will then notify the Company's Quality Management Committee and report the grievance to that Quality Management Committee. The Quality Management Committee will decide what action is appropriate, if any.

Additionally, the Company handles complaints based upon the manner in which it was received. If

the complaint was oral, the Company will research and respond to the customer orally. If the complaint was written, the Company will respond in writing. If the Company makes a determination that results in a reduction or denial of benefits, the insured may appeal that decision according to the Standard Appeals Section of the Company's Complaints and Grievances Manual. This appeal may be considered the second level of review.

The examiners were satisfied that all second level reviews of grievances as defined by the NAIC are reviewed by the Company in accordance with statutes, rules, and regulations.

This standard was tested generically; therefore, there are not statistics to report.

Recommendations: None

Standard C-6 – The health carrier handles grievances involving adverse utilization review determinations in compliance with statutes, rules, and regulations.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-04-03(10), 26.1-36-03.1)

Comments: Review methodology for this standard is sample. This standard does have a direct insurance statutory requirement.

Results: Pass

Observations: A random sample of grievance files from the complaint logs for the examination period was requested for review by the examiners. The concerns tested with this standard are that:

1. The grievances involving adverse utilization review determinations are appropriate.

2. Reviewers have the appropriate level of expertise.

3. All conflicts of interest on the part of reviewers are avoided.

The examiners are satisfied that the sample of complaints and grievances reviewed within the scope of this examination and specifically addressed within the B Standards involving adverse utilization review were handled in accordance with North Dakota statutes, rules, and regulations. This issue was indirectly addressed within Standards B-2 and B-3. The examiners reviewed a sample of correspondence (complaints/grievances) and tested the correspondence within the B Standards. Implicit in that review was an overall review of the complaint and grievance handling.

The Company has two types of appeals—expedited and standard. Within the expedited (or emergency) appeals, medical information is reviewed by the Medical Director. If the provider or insured disagree with that decision, they have the opportunity to make a standard appeal. The standard appeal has two levels of review. The information is initially reviewed by the Medical Director and, if necessary, is then reviewed by a consultant or panel at the discretion of the Medical Management Department. Such a setup assures that the reviewers have the necessary level of expertise and also assists in avoiding conflicts of interest.

After reviewing the sample provided, the examiners determined that a specific analysis of the above standard was not necessary. Rather, a general analysis would be sufficient. Therefore, this standard was not tested by sample and there are no statistics to report.

Recommendations: None

Standard C-7 – The health carrier has procedures for and conducts expedited appeals in compliance with statutes, rules, and regulations.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-04-03(10), 26.1-36-03.1)

Comments: Review methodology for this standard is sample. This standard does have a direct insurance statutory requirement.

Results: Pass

Observations: A random sample of grievance files from the complaint logs for the examination period was requested for review by the examiners. The concerns tested with this standard are that:

1. Expedited appeals are offered under appropriate conditions.

2. Appropriate reviewers are utilized for expedited appeals.

3. Expedited appeal decisions are made timely.

The Company has two types of appeals. They are standard appeals and expedited appeals. An understanding of how the Company defines a standard appeal is necessary to understand how the Company defines an expedited appeal. The Company defines standard appeals as "a statement (oral/written) expressing disagreement with a decision made by [the Company] and requesting a change in that decision." The Company defines an expedited appeal as "an appeal (oral or written) in which the time frame for the standard process could seriously jeopardize the member's life, health, or ability to regain maximum functioning."

From the definition, it is clear that the Company allows expedited appeals in emergency situations. According to the Company's Appeals and Grievances Manual, "if the Company makes a determination that results in a partial authorization or denial of authorization (reduction or non-certification of benefits), an immediate or expedited appeal may be made via telephone by the attending physician." Additionally, "access to the Medical Director who made the initial determination will be available within one (1) business day to discuss the expedited appeal."

The expedited appeals process may be initiated by the attending physician by either calling the Company's Provider Services Department or by calling the Medical Director. The Medical Director will then review the documentation and request additional documentation if necessary. The Medical Director will make a decision to reverse or uphold the original determination within one business day and will notify the attending physician by telephone. A written notification is then sent to the provider and the insured of the Medical Director's decision. If the original determination is upheld, the provider or the insured maintain their right to appeal the decision through the standard appeals process. If the provider or the insured appeals the decision through the standard appeals process, the claim is not reviewed by the same Medical Director who made the denial in the expedited appeals process.

The examiners are satisfied that the Company has procedures for and conducts expedited appeals in accordance with statutes, rules, and regulations.

This standard was tested generically; therefore, no sample statistics are reported.

Recommendations: None

Marketing and Sales

The evaluation of standards in this business area is based on review of Company responses to information requests, questions, interviews, and presentations made to the examiner. This portion of the examination is designed to evaluate the representations made by the Company about its product(s). It is not typically based on sampling techniques but can be. The areas to be considered in this kind of review include all media (radio, television, videotape, etc.), written and verbal advertising, and sales materials.

Standard D-1 – All advertising and sales materials are in compliance with applicable statutes, rules, and regulations.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-04-03(2); NDAC Chapter 45-06-04, § 45-06-05-09.1)

Comments: Review methodology for this standard is generic. This standard has a direct insurance statutory requirement. This standard is intended to assure compliance with the prohibitions on misrepresentation. It is concerned with all forms of media (print, radio, television, etc.).

Results: Pass

Observations: The examiner noted two distinct types of advertising that could generally be categorized as general name recognition and direct sales information. The distinction between the two is that the former is generating general interest and name recognition of the Company's logo and services. It includes such forms of media such as direct mailings, radio and television advertisements, and some print advertising. This type of advertising is general in nature while the direct sales information is specifically designed for sales presentation and includes details regarding insurance coverage under any particular policy.

With respect to the general advertising, the examiner found the material provided to be consistent with the Company's policies for advertising. The Company's policy for advertising is contained in a publication entitled, "The Brand Book." The Brand Book lists general requirements for advertising the Company's logo and other information. The Brand Book sets up things such as colors, font size, logo location, etc. All of the general advertising appeared to be in conformity with the Company's own requirements.

With respect to the direct sales information, the examiner reviewed sales brochures and cross-referenced the advertised benefits with the covered services. For example, the examiner would determine the corresponding Summary Plan Description that would relate to a particular sales brochure. Once that connection was made, the examiner determined whether the brochure accurately defined the terms deductible, copayment, and coinsurance. Additionally, the examiner would match the coverage for various services such as well child care within the sales brochure to the coverage for well child care within the Summary Plan Description. The examiner did not find any discrepancies within the materials reviewed.

The advertising and sales materials are in compliance with applicable statutes, rules, and regulations.

Recommendations: None

Standard D-2 – Company internal producer training materials are in compliance with applicable statutes, rules, and regulations.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-04-03(2); NDAC Chapter 45-06-04)

Comments: Review methodology for this standard is generic. This standard has a direct insurance statutory requirement. This standard is intended to assure compliance with the prohibitions on misrepresentation. It is concerned with training or instructional representations made by the Company to its producers.

Results: Pass

Observations: The Company provided the examiners with two Agents Manuals on CD-ROM. The examiners reviewed the material on both discs. Using Microsoft Explorer, the examiners were able to open the various documents on the discs to a Microsoft Internet Explorer. The discs contained valuable information for agents concerning a wide variety of topics such as eligibility for various forms of coverage, the Agent Code of Conduct, and forms for agent use such as rate sheets. Some of the documents were maintained in an Adobe Acrobat format thus allowing agents to print and use the forms. The examiners spot checked the information contained within the manual and determined that the Company internal producer training materials are in compliance with applicable statutes, rules, and regulations

Recommendations: None

Standard D-3 – Company communications to producers are in compliance with applicable statutes, rules, and regulations.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-04-03(3); NDAC Chapter 45-06-04)

Comments: Review methodology for this standard is generic. This standard has a direct insurance statutory requirement. This standard is intended to assure compliance with the prohibitions on misrepresentation. It is concerned with representations made by the Company to its producers in other than a training mode.

Results: Pass

Observations: The Company has both captive and non-captive agents. All of the agents are trained annually at the agent workshop. The workshop provides an opportunity for the Company to communicate any changes to procedures or new procedures to all agents. This workshop is the primary method of training and communicating with non-captive agents. Captive agents also attend the annual agent workshop. The Company's district managers have direct contact with all captive agents and can communicate with them personally or through the Company's email. The Company generally communicates with all non-captive agents simultaneously via written correspondence. Additionally, the Company may also communicate individually with non-captive agents via correspondence including fax, mail, or possibly email.

The examiners were satisfied that all communications with producers are in compliance with North Dakota statutes, rules, and regulations.

Recommendations: None

Standard D-4 – Company rules on replacement are in compliance with applicable statutes, rules, and regulations.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-04-03(2); NDAC Chapter 45-06-04)

Comments: Review methodology for this standard is generic. This standard has a direct insurance statutory requirement. This standard is intended to assure compliance with the prohibitions on misrepresentation. It is concerned with appropriate replacement practices.

Results: Pass

Observations: The NAIC drafted a model regulation requiring insurance companies to provide notice to an insured upon the replacement of an accident and sickness insurance policy. The notice generally intended to inform the insured of new waiting periods and preexisting conditions, and informed the insured how the new policy may be limited by those issues.

The Health Insurance Portability and Accountability Act located in 29 U.S.C. §§ 1181-1191 has addressed and changed the needs for this type of requirement. The Company's application form, in Section 4, inquires into previous health coverage. The enactment of the Health Insurance Portability and Accountability Act allows insureds with existing coverage to change insurance companies without applying new waiting period requirements. Therefore, the issues raised by this standard have been addressed. The Company's rules on replacement are in compliance with applicable statutes, rules, and regulations.

Recommendations: None

Standard D-5 – Outline of coverages is in compliance with applicable statutes, rules, and regulations.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, Chapter 26.1-36.3; NDAC Chapter 45-06-06.1)

Comments: Review methodology for this standard is generic. This standard has a direct insurance statutory requirement. This standard is aimed at assuring compliance with the prohibitions on misrepresentation. It is concerned with representations made by the Company to its members through misleading outlines of coverage.

Results: Pass

Observations: The Company files with the North Dakota Insurance Department a Certificate of Insurance and Summary Plan Description for each policy that it issues. This Summary Plan Description provides an outline of coverage for each insured. Upon review of the Summary Plan Description, the examiner is satisfied that the outline of coverage is in compliance with applicable statutes, rules, and regulations.

Recommendations: None

Standard D-6 – Company has suitability standards for its products when required by applicable statutes, rules, and regulations.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-26-42, 26.1-36.1-02, Chapter 26.1-45; NDAC § 45-02-02-14)

Comments: Review methodology for this standard is generic. This standard has a direct insurance statutory requirement. This standard is intended to assure compliance with the prohibitions on

misrepresentation. It is concerned with appropriateness of the offerings of Medicare supplement coverage and long term care coverage.

Results: Pass

Observations: The examiner notes that the Company has in place a system for determining whether multiple policies of insurance have been issued to the same insured. This is tracked using the policyholder's Social Security number. When a policy is sold, the Social Security number is run through a database to determine whether coverage currently exists through the company. If coverage is found to exist, the Company's Member Services Division will contact the insured to determine whether the coverage should be maintained or canceled. Additionally, on an initial purchase of insurance, the prospective insured is offered a variety of policies and the prospective insured ultimately decides what amount of coverage would be suitable.

The examiner is satisfied that the Company has proper suitability standards for the sale of its individual and group insurance policies.

Recommendations: None

Standard D-7 – Marketing for long term care products complies with state laws.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, Chapter 26.1-45; NDAC Chapter 45-06-05)

Comments: Review methodology for this standard is generic. This standard has a direct insurance statutory requirement. This standard is intended to assure compliance with the prohibitions on misrepresentation. It is concerned with appropriate practices related to long term care coverage.

Results: Not tested

Observations: The scope of this examination did not include long term health care policies. Therefore, this standard was not tested.

Recommendations: None

Network Adequacy

This business area was not tested during this examination. The evaluation of standards in this business area is based on review of Company responses to information requests, questions, interviews, and presentations made to the examiner. This portion of the examination is designed to assure that a Company offering managed care plans maintain service networks that are sufficient to assure that all services are accessible without unreasonable delay. The standards require the Company to assure the adequacy, accessibility, and quality of health care services offered through their service networks. Standards normally considered in this business area include:

Standard E-1 The Company demonstrates, using reasonable criteria, that it maintains a network that is sufficient in number and types of providers to assure that all services to covered persons will be accessible without unreasonable delay.

Standard E-2 The Company files an access plan with the Commissioner for each managed care plan that the carrier offers in the state, and files updates whenever it makes a material change to an existing managed care plan The carrier makes the access plans available (1) on its business premises, (2) to regulators, and (3) to interested

parties absent proprietary information upon request.

Standard E-3 The Company files with the Commissioner all required contract forms, and any material changes to a contract, proposed for use with its participating providers and intermediaries.

Standard E-4 The Company ensures covered persons have access to emergency services 24 hours per day, 7 days per week within its network and provides coverage for emergency services outside of its network pursuant to N.D. Cent. Code § 26.1-36-03.1(1) (h).

Standard E-5 The Company executes written agreements with each participating provider that are in compliance with statutes, rules, and regulations.

Standard E-6 The Company's contracts with intermediaries are in compliance with statutes, rules, and regulations.

Standard E-7 The Company's arrangements with participating providers comply with statutes, rules, and regulations.

Standard E-8 The Company provides at enrollment a Provider Directory listing all providers participating in its network. It also makes available, on a timely and reasonable basis, updates to its directory.

Producer Licensing

The evaluation of standards in this business area is based on review of North Dakota Insurance Department information and Company responses to information requests, questions, interviews, and presentations made to the examiner. This portion of the examination is designed to test the Company's compliance with North Dakota producer licensing laws and rules.

Standard F-1 – Company records of licensed and appointed producers agree with North Dakota Insurance Department records.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-26-03, 26.1-26-13)

Comments: This standard has a direct insurance statutory requirement. It is not file specific. This standard is aimed at assuring compliance with the requirement that producers be properly licensed and appointed. Such producers are presumed to be qualified, having met the test for such license.

Results: Pass (but needs improvement)

Observations: The initial investigation caused the examiner some concerns. The Company's initial listing of active agents provided to the examiners did not correspond to the records maintained by the North Dakota Insurance Department. The examiner found two main problems with the listing provided. First, some of the agents listed on the Company's list were not appointed to sell insurance for the Company either because no appointment had occurred or because the appointment was non-renewed. Second, the Company's listing included some agents that were not licensed. The Company has stated that they were in the process of getting information transferred to an on-line system and that all the information requested had not been transferred. Paper copies of all necessary appointment information were in the agents' files.

As a result of this finding, additional investigation was warranted. The Company provided an updated listing of agent appointments. Upon the second review, the examiner still found some discrepancies between the information maintained by the North Dakota Insurance Department and the Company. The examiner returned to the Company to determine whether there was simply a discrepancy between the records or whether agents were actually selling insurance without proper appointment. The examiner determined that while it is possible that some agents may have sold insurance policies prior to his or her appointment with the Company, the crux of the discrepancy was the result of prior manual or noncomputerized record keeping.

The examiner discussed the problem with representatives from the Company and was reassured that more accurate record keeping is currently under continued development. The Company's representatives showed the examiner the changes in current record keeping in comparison to the prior record keeping. The examiner was satisfied with the explanation. The examiner then explained to the Company that this area will be reviewed closely during the next examination to monitor improvements.

Recommendations: Continue updating and maintaining the Company's database of appointed agents and agencies to correspond to the proper licensure and appointment requirements and periodically check the database for accuracy.

Standard F-2 – The producers are properly licensed, and if an agent appointed, for insurance solicited in North Dakota.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-26-03, 26.1-26-13)

Comments: This standard has a direct insurance statutory requirement. As applied in this section, it is not file specific. This standard is aimed at assuring compliance with the requirement that producers be properly licensed and appointed for business solicited in North Dakota.

Results: Pass (but needs improvement)

Observations: The comments from Standard F-1 apply to this standard as well.

The Company's listing of active agents initially provided to the examiners did not correspond to the records maintained by the North Dakota Insurance Department. The examiner found two main problems with the listing provided. First, many of the agents listed on the Company's list were not appointed to sell insurance for the Company either because no appointment had occurred or because the appointment was non-renewed. Second, the Company's listing included some agents that were not licensed.

The additional investigation discussed in Standard F-1 provided the examiner with some reassurance that this possible problem is being addressed by the company.

Recommendations: None

Standard F-3 – Termination of producers complies with statutes regarding notification to the producer and notification to the State of North Dakota.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-26-03, 26.1-26-13)

Comments: This standard has a direct insurance statutory requirement. It is generally not file specific. This standard is aimed at avoiding unlicensed placements of insurance.

Results: Pass

Observations: The Company has a policy for notifying the North Dakota Insurance Department of any terminations for cause. Therefore, the Company's procedures for notifying the North Dakota Insurance Department complies with statutes, rules, and regulations. Additionally, the examiner notes that no producers were terminated for cause during the examination period.

Recommendations: None

Standard F-4 – The Company's policy of producer appointments and terminations do not result in unfair discrimination against policyholders.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-26-03, 26.1-26-13)

Comments: This standard has a direct insurance statutory requirement. It is generally not file specific. This standard is concerned with potential geographical discrimination through the insurer's selection and instructions to its producers. The tests are intended to expose indicators of such practice and may not be conclusive.

Results: Pass

Observations: The examiner did not find that the Company's policy of producer appointments and terminations resulted in any unfair discrimination against policyholders. Additionally, outside of the Company's policy on appointments and terminations, the examiner notes that the actual appointments and terminations did not appear to result in unfair discrimination against policyholders either.

Recommendations: None

Standard F-5 – Records of terminated producers adequately document reasons for terminations.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-26-03, 26.1-26-13, 26.1-26-34)

Comments: This standard has a direct insurance statutory requirement. It is generally file specific. This standard is intended to aid in the identification of producers involved in unprofessional behavior which is harmful to the public.

Results: Pass

Observations: The Company provided the examiners with a listing of all terminated agents during the examination period. The Company noted in its response to our inquiry that no agent was terminated for cause during the examination period. Therefore, the listing of terminated agents was sufficient information since the agents were not terminated for cause.

The Company is required to notify the North Dakota Insurance Department of all terminations of agents and agencies. The notification form includes an area in which the company is required to designate whether or not the termination is for cause. If the termination is for cause, the Company is required to list the reasons for the termination for cause.

The examiners are satisfied that the records of terminated producers adequately document the reasons for termination.

Recommendations: None

Standard F-6 – Producer accounts current (account balances) are in accordance with the producer's contract with the insurer.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-26-03, 26.1-26-13, 26.1-26-42)

Comments: This standard has a direct insurance statutory requirement. It is generally file specific. The focus of this standard is to aid in the detection of fraud or misuse of funds held by the producer in a fiduciary capacity. N.D. Cent. Code § 26.1-26-42(10) states:

> The commissioner may suspend, revoke, place on probation, or refuse to continue or refuse to issue any license issued under this chapter if, after notice to the licensee and hearing, the commissioner finds as to the licensee any of the following conditions:
>
> . . .
>
> 10. An improper withholding of, misappropriating of, or converting to one's own use any moneys belonging to policyholders, insurers, beneficiaries, or others received in the course of one's insurance business.

Results: Pass

Observations: The examiners discovered that when a person is applying for individual coverage, the applicant will provide a check to the agent for the first premium payment. When an application is processed, a check must be submitted with the application before processing can occur. After individual coverage is provided the insured is billed for the premium payments. Individuals' premiums may be deducted from the insured's checking account directly or the insured has the option to mail payment to the company. With group applications, the group holder is billed for the premium and the agent generally does not handle any funds. As such, there are very few, if any, producer accounts at issue with regard to this standard.

The examiners are satisfied that the issue raised and addressed by this standard has been satisfied.

Recommendations: None

Provider Credentialing

This business area was not tested during this examination. The evaluation of standards in this business area is based on review of Company responses to information requests, questions, interviews, and presentations made to the examiner. This portion of the examination is designed to assure that companies offering managed care plans have verification programs to ensure that participating health care professionals meet minimum specific standards of professional qualification. The areas to be considered in this kind of review include the company's written credentialing and recredentialing polices and procedures, the scope and timeliness of verifications, role of health professionals in ensuring accuracy, and oversight of any delegated verification functions. Standards normally considered in this business area include:

Standard G-1 The Company establishes and maintains a program for credentialing and re-

credentialing in compliance with statues, rules, and regulations.

Standard G-2 The Company verifies the credentials of a health care professional before entering into a contract with that health care professional.

Standard G-3 The Company obtains primary verification of the information required.

Standard G-4 The Company obtains credentialing information through either a primary or secondary credentialing verification process.

Standard G-5 The Company obtains primary verification of the credentialing information at least every three years.

Standard G-6 The Company requires all participating providers to notify the Company's designated individual of changes in the status of any information that is required to be verified by the Company.

Standard G-7 The Company provides a health care professional the opportunity to review and correct information submitted in support of that health care professional's credentialing verification.

Standard G-8 The Company monitors the activities of the entity with which it contracts to perform credentialing functions and ensures the requirements of applicable statutes rules and regulations are met.

Policyholder Services

The evaluation of standards in this business area is based on review of Company responses to information requests, questions, interviews, and presentations made to the examiner and file sampling during the examination process. The policyholder service portion of the examination is designed to test a company's compliance with statutes regarding notice/billing, delays/no response, premium refund, and coverage questions.

Standard H-1 – Premium notices and billing notices are sent out with an adequate amount of advance notice.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-03-19.3)

Comments: This standard has a direct insurance statutory requirement. It is generally file specific. The focus of this standard is Company provision to insureds with information in a timely fashion so they can make informed decisions.

Results: Pass

Observations: The Company has a policy of sending out premium notices and billing statements with a 30-day advance notice. The examiners are satisfied that the issue raised by this standard is satisfied by the Company's policies.

Recommendations: None

Standard H-2 – Policy issuance and insured-requested cancellations are timely and appropriate.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-03-19.3)

Comments: This standard does not have a direct insurance statutory requirement. It is generally file specific. The focus of this standard is Company provision to insureds with information in a timely fashion so they can make informed decisions.

Results: Pass

Observations: Both policy issuance and policy cancellation are handled within the Company's Membership Services Division. The Company's standard timeline for policy issuance is within 30 days of receipt of the completed application. The Company's standard timeline for policy cancellation is within five business days of receipt of notification. For individual policies, written notification requesting cancellation is required. At an insured's request, a cancellation notification form is sent to the insured. The written notification must be received prior to the requested cancellation date. Individual policies are cancelled on the 15th or the last day of the month the notification was received. Thus, the cancellation is processed within five business days, but the coverage remains in effect until the 15th or the last day of the month. When an individual under a group policy leaves group coverage, the cancellation is processed within five days and the coverage lapses once the cancellation notification is processed.

The examiners are satisfied that the policy issuance and insured requested cancellations are timely and appropriate.

Recommendations: None

Standard H-3 – All correspondence directed to the Company is answered in a timely and responsive manner by the appropriate department.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-03-19.3)

Comments: This standard has a direct insurance statutory requirement. It is generally file specific. The focus of this standard is Company provision to insureds with information in a timely fashion so they can make informed decisions.

Results: Pass

Observations: As noted earlier in the report, the Company has an Inquiry Tracking System that tracks all forms of correspondence with the Company. According to Company policy, each inquiry is directed to the appropriate personnel for response. The examiner notes that the Company has imposed time limits for response and strives to meet that time limit. The examiners are satisfied that correspondence directed to the Company is answered in a timely and responsive manner by the appropriate department.

Recommendations: None

Standard H-4 – Reinstatement is applied consistently and in accordance with policy provisions.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-03-19.3)

Comments: None

Results: Pass

Observations: The examiners note that the Company's reinstatement information that is provided to the insured is identical to a new policy issuance. Thus, when a policy is reinstated, the insured is given a new Summary Plan Description and is issued a new coverage card, both of which reflect the current coverage in terms of policy type and effective dates. The examiners are satisfied that the reinstatement of policies is consistent with the various policies' provisions.

Recommendations: None

Standard H-5 – Policy transactions are processed accurately and completely.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-03-19.3)

Comments: None

Results: Pass

Observations: The examiners are satisfied that all policy transactions are processed accurately and completely. Proper documentation is maintained for original applications and request changes. The application has a check box indicating whether the policy to be issued is intended to be a new policy or whether the application is intended to create a change in coverage. Once an application is entered into the Company's computer system, the hardcopy of the application is copied onto microfilm and is destroyed.

With respect to timeliness of new and changed applications, the Company has a self imposed time limit of turning over all insurance identification cards and other insurance materials to the insured with 30 days or prior to the effective date of the policy. Further, it appears as though the Company only allows non-renewal for proper reasons, and that the Company appears to be in compliance with continuation of coverage requirements of HIPAA and COBRA.

Recommendations: None

Standard H-6 – Nonforfeiture options are communicated to the policyholder and correctly applied in accordance with the policy contract.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, Chapter 26.1-45; NDAC Chapter 45-06-05)

Comments: None

Results: Not tested

Observations: This standard is applicable to long term care products which are not being tested in this examination.

Recommendations: None

Standard H-7 – Evidence of creditable coverage is provided in accordance with the requirements of HIPAA and/or statutes, rules, and regulations.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, Chapter 26.1-45; NDAC Chapter 45-06-05)

Comments: None

Results: Not tested

Observations: This standard is applicable to long term care products which are not being tested in this examination.

Recommendations: None

Standard H-8 – Whenever the Company transfers the obligation of its contracts to another company pursuant to an assumption reinsurance agreement, the Company has gained prior approval of the Insurance Department and the Company has sent the required notices to its affected policyholders.
(NDCC §§ 26.1-02-03, 26.1-03-19.2)

Comments: None

Results: Not tested

Observations: This standard is applicable to situations where an assumption reinsurance agreement exists. This is not applicable to this examination.

Recommendations: None

Standard H-9 – Policyholder service for long term care products complies with state laws.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, Chapter 26.1-45; NDAC Chapter 45-06-05)

Comments: None

Results: Not tested

Observations: This standard is applicable to long term care products which are not being tested in this examination.

Recommendations: None

Quality Assessment and Improvement

This business area was not tested during this examination. The evaluation of standards in this business area is based on review of Company responses to information requests, questions, interviews, and presentations made to the examiner. This portion of the examination is designed to assure that companies offering managed care plans have quality assessment programs in place that enable the company to evaluate, maintain, and, when required by state law, improve the quality of health care services provided to covered persons. For managed care plans that limit covered persons to a closed network, the standards also require a quality improvement program with specific goals and strategies for measuring progress toward those goals. Standards normally

considered in this business area include:

Standard I-1 The Company develops and maintains a quality assessment program in compliance with statutes, rules, and regulations.

Standard I-2 The Company files a written description of the quality assessment program with the Commissioner in the prescribed format, which shall include a signed certification by a corporate officer of the Company that the filing meets statutes, rules, and regulations.

Standard I-3 The Company develops and maintains a quality improvement program in compliance with statues, rules, and regulations.

Standard I-4 The Company reports to the appropriate licensing authority any persistent pattern of problematic care provided by a provider that is sufficient to cause the Company to terminate or suspend contractual arrangements with the provider.

Standard I-5 The Company documents and communicates information about its quality assessment program and its quality improvement program to covered persons and providers.

Standard I-6 The Company annually certifies to the Commissioner that its quality assessment and quality improvement program along with the materials provided to providers and consumers meet applicable requirements.

Standard I-7 The Company monitors the activities of the entity with which it contracts to perform quality assessment or quality improvement functions and ensures that the requirements of applicable statutes, rules, and regulations are met.

Underwriting and Rating

The evaluation of standards in this business area is based on review of Company responses to information requests, questions, interviews, presentations made to the examiner, and file sampling. The underwriting and rating practices portion of the examination is designed to provide a view of how the Company treats the public and whether that treatment is in compliance with applicable statutes, rules, and regulations. It is typically determined by testing a random sampling of files and applying various tests to the sampled files. It is concerned with compliance issues.

In this examination, file sampling of underwriting files was generally not used. This was due to the fact that review of the policies and procedures indicate that the elements of Company operations tested with these standards are generally subject to adequate controls and the review was deemed by the examiners to be unnecessary. Company controls are in place and the underwriting operations are well managed.

Standard J-1 – The rates charged for the policy coverage are in accordance with filed rates or the Company rating plan.
(NDCC §§ 26.1-02-03, 26.1-03-19.2)

Comments: This standard has a direct insurance statutory requirement. It is file specific. It is necessary to determine if the company is in compliance with rating systems which have been filed with and approved by the North Dakota Insurance Department. Rates should not be unfairly

discriminatory. Wide-scale application of incorrect rates by a Company may raise financial solvency questions or be indicative of inadequate management oversight. Deviation from established rating plans may also indicate a company is engaged in unfair competitive practices.

Results: Not tested

Observations: None

Recommendations: None

Standard J-2 – All mandated disclosures are documented and in accordance with applicable statutes, rules, and regulations.
(NDCC §§ 26.1-02-03, 26.1-03-19.2)

Comments: Review methodology for this standard is generic. This standard has a direct insurance statutory requirement. It is necessary to provide insureds with appropriate disclosures, both mandated and reasonable. Without appropriate disclosures, insureds find it difficult to make informed decisions.

Results: Pass

Observations: A random sample of files was not reviewed for this examination. Concerns tested with this standard were tested by a review of the related Company policies and procedures. These concerns include:

1. Whether quotations are documented, accurate, and timely as supported by data in underwriting file.

2. Whether changes in coverage are disclosed timely.

3. Whether changes in renewal rates are disclosed timely.

4. Whether all mandated offers of coverage have been disclosed.

The Company's policies and procedures satisfy all of the above-listed concerns. The Company, or its agent, informs the applicant of each type of insurance coverage the applicant qualifies for and the applicable rates including all mandated offers of coverage. The applicant then makes the decision of which coverage to accept. Once coverage is accepted, the insured is timely notified of changes in coverage and renewal rates. Lastly, North Dakota requires all forms and rates to be filed and approved prior to use. Therefore, all forms and rates have been approved.

Recommendations: None

Standard J-3 – Company does not permit illegal rebating, commission cutting, or inducements.
(NDCC §§ 26.1-02-03, 26.1-03-19.2)

Comments: Review methodology for this standard is generic. This standard has a direct insurance statutory requirement. Illegal rebating, commission cutting, or other illegal inducements are a form of unfair discrimination.

Results: Pass

Observations: A random sample of files was not reviewed during this examination. Concerns tested with this standard were tested by a review of the related Company policies and procedures. These subjects include:

1. Whether the Company had consistent use of commission schedule.

2. Whether the Company could verify and explain commission variances.

3. Whether the Company's agent contracts contained commission provisions.

4. Whether the Company maintained proper documentation of credits and deviations.

The Company's Marketing Department is responsible for ensuring that the Company does not permit illegal rebating, commission cutting, or inducements. The Company provided the examiners with a written explanation of the commission schedules for both captive and non-captive agents. The Company's commission schedule provides for a flat rate commission payment based upon the collection of the insurance premiums. A general review of commission payments showed a consistent use of this flat rate. The examiners did not do a sample review of the commissions paid thus no variance of the commission schedule was discovered or required explanation.

The examiners also reviewed the Company's agent or broker contracts. The Company's contract with the agents explains the commission that will be paid. Additionally, the Company's contract contains a provision limiting the authority of agents to provide rebates. Finally, the Company provided a detailed list of commissions that were paid. It appears as though adequate documentation existed with respect to this issue.

Recommendations: None

Standard J-4 – All forms including contracts, riders, endorsement forms, and certificates are filed with the North Dakota Insurance Department, if applicable.
(NDCC §§ 26.1-02-03, 26.1-03-19.2)

Comments: Review methodology for this standard is generic. This standard has a direct insurance statutory requirement.

Results: Pass

Observations: A random sample of files was not reviewed during this examination. Concerns tested with this standard were tested by a review of the related Company policies and procedures. These subjects include:

1. Whether all forms and endorsements are properly filed with the North Dakota Insurance Department, if applicable.

2. Whether all forms and endorsements that form part of the contract are listed on the declarations page.

After reviewing the materials provided by the Company, the Examiners were satisfied that the Company complies with this requirement.

Recommendations: None

Standard J-5 – The Company underwriting practices are not unfairly discriminatory. The Company adheres to applicable statutes, rules, and regulations and Company guidelines in the selection of risks.
(NDCC §§ 26.1-02-03, 26.1-03-19.2)

Comments: Review methodology for this standard is generic. This standard has a direct insurance statutory requirement. It is necessary to provide insureds with appropriate protections from unfair discrimination. Inconsistent handling of rating or underwriting practices, including requests for supplemental information, even if not intentioned, can result in unfair discrimination.

Results: Pass

Observations: A random sample of files was not reviewed during the examination. Concerns tested with this standard were tested by a review of the related Company policies and procedures. These subjects include:

1. Whether there is consistent application of underwriting criteria.

2. Generally whether the Company is following its underwriting guidelines.

The Company's Underwriting Manual and all of its updates are maintained online. The Company's underwriting practices are consistent with its policy. The examiners did not do a specific test of randomly selected files to determine whether there was consistent application of underwriting criteria; however, those files that were reviewed throughout the course of this examination satisfied the examiners that consistent application of underwriting criteria occurs.

Recommendations: None

Standard J-6 – Producers are properly licensed and appointed for the jurisdiction where the application was taken.
(NDCC §§ 26.1-02-03, 26.1-03-19.2)

Comments: Review methodology for this standard is sample. This standard has a direct insurance statutory requirement.

Results: Not tested

Observations: None

Recommendations: None

Standard J-7 – File documentation adequately supports decisions made.
(NDCC §§ 26.1-02-03, 26.1-03-19.2)

Comments: Review methodology for this standard is generic. This standard does not have a direct insurance statutory requirement. When underwriting is done with less than the required information, the likelihood of unfair discrimination increases.

Results: Pass

Observations: A random sample of files was not reviewed during the examination. Concerns tested with this Standard were tested by a review of the related Company policies and procedures. These subjects include:

1. whether underwriting file contains complete and signed application.

2. Whether the application contains sufficient information to identify exposure.

An actual underwriting file does not exist in one central location. Per a discussion with the Company's staff from rating, the examiners determined that all material necessary to determine the extent of liability exposure is available from different locations. Adequate documentation exists within the Company to support its decisions.

Recommendations: None

Standard J-8 – Policies, riders, and endorsements are issued or renewed accurately, timely, and completely.
(NDCC §§ 26.1-02-03, 26.1-03-19.2)

Comments: Review methodology for this standard is generic, sample, and electronic. This standard does not have a direct insurance statutory requirement.

Results: Pass

Observations: A random sample of files was not reviewed during the examination. Concerns tested with this standard were tested by a review of the related Company policies and procedures. These subjects include:

1. Whether policies and endorsements are issued in appropriate timeframes.

2. Whether policies are issued or rejected within a reasonable time following completion of the application.

As noted in Standard H-2, both policy issuance and cancellations are handled within the Company's Membership Services Division. The Company's standard timeline for policy issuance is within 30 days of receipt of the completed application. Thus, policies are issued or rejected within a reasonable time frame. The Company does not issue riders on any of its policies. Rather, the Company allows insureds to switch between policies to either gain or lessen any certain amounts of coverage. Thus, the timeliness of policy issuance and cancellation is the key element in addressing this standard. The examiners believe this standard is satisfied.

Recommendations: None

Standard J-9 – Rejections and declinations are not unfairly discriminatory.
(NDCC §§ 26.1-02-03, 26.1-03-19.2)

Comments: Review methodology for this standard is generic, sample, and electronic. This standard has a direct insurance statutory requirement. Consistent application of a company's underwriting rules is the primary method used to avoid unfair discrimination.

Results: Pass

Observations: A random sample of files was not reviewed during the examination. Concerns tested with this standard were tested by a review of the related Company policies and procedures. These subjects include:

1. Whether valid reasons for rejection/declination are provided.

2. Whether unfair discriminatory practices are avoided.

The examiners are satisfied after reviewing general underwriting criteria that valid reasons exist when the Company refuses to offer coverage. Additionally, the examiners are satisfied that through the use of the underwriting criteria, unfair discrimination is avoided.

Recommendations: None

Standard J-10 – Cancellation/nonrenewal/discontinuance notices comply with policy provisions and state laws including the amount of advance notice provided to the insured and other parties to the contract.
(NDCC §§ 26.1-02-03, 26.1-03-19.2)

Comments: Review methodology for this standard is generic, sample, and electronic. This standard has a direct insurance statutory requirement. Cancellation/nonrenewal notice timeframe requirements arose out of abuses that still exist generally within the industry. Policyholders need sufficient time in the event of a cancellation or nonrenewal to replace coverage.

Results: Pass

Observations: A random sample of files was not reviewed during the examination. Concerns tested with this standard were tested by a review of the related Company policies and procedures. These subjects include:

1. Whether a reason given for cancellation/nonrenewal was valid according to policy provisions and statute.

2. Whether the notice of cancellation includes the specific reason for cancellation where required.

3. Whether adequate notice of a cancellation/nonrenewal was provided to the insured.

The Company's Legal and Membership Departments are in charge of policy cancellations. The time standard for policy cancellation is within five days of receipt of notification. The examiner reviewed the standard form letters used to notify the insured of a cancellation of coverage. The various reasons given within each form letter are consistent with policy provisions and North Dakota law. Additionally, the letters provide adequate notice to the insured of the cancellation. The main reason for a cancellation is the nonpayment of premiums.

Recommendations: None

Standard J-11 – Cancellation practices comply with policy provisions, HIPAA, and state laws.
(NDCC §§ 26.1-02-03, 26.1-03-19.2)

Comments: Review methodology for this standard is sample. This standard has a direct insurance statutory requirement.

Results: Pass

Observations: A random sample of files was not reviewed during the examination. Concerns tested with this standard were tested by a review of the related Company policies and procedures. These subjects include:

1. Whether the reason for termination was valid according to statute.

The examiners reviewed the policies and procedures relating to policy cancellations. The examiners are satisfied that cancellation practices comply with policy provisions, HIPAA, and state law.

Recommendations: None

Standard J-12 – Unearned premiums are correctly calculated and returned to the appropriate party in a timely manner and in accordance with applicable statutes, rules, and regulations.
(NDCC §§ 26.1-02-03, 26.1-03-19.2)

Comments: Review methodology for this standard is sample and electronic. This standard does not have a direct insurance statutory requirement. Prompt return of unearned premiums assist insureds in replacing coverage.

Results: Not tested

Observations: None

Recommendations: None

Standard J-13 – Rescissions are not made for nonmaterial misrepresentation.
(NDCC §§ 26.1-02-03, 26.1-03-19.2)

Comments: This standard does not have a direct insurance statutory requirement. It is file specific. Rescissions generally occur after a claim has been filed. A large number of rescissions can reflect inadequate underwriting efforts. When rescissions are made it should not be for trivial or nonmaterial reasons.

Results:

Observations: A seriatim sample of files as noted in the following table was reviewed from the listing of contracts in force during the examination period. Concerns tested with this standard include:

1. Rescissions do not indicate a trend toward post claim underwriting.

2. Rescissions are for material reasons.

Type	Sampled	N/A	Pass	Fail	% Pass
00-01 Policies rescinded	9	0	9	0	100
Total	9	0	9	0	100

A total of nine policies were rescinded during the period under examination. A review of those files did not indicate a trend toward post claim underwriting practices. Additionally, all of the rescissions appear to be made in accordance with applicable statutes, rules, and regulations. It should be noted that all rescissions were made based upon what the Company considers a material misrepresentation on the application. The application contains a series of questions regarding prior health conditions which the applicant must answer either yes or no. The responses to these questions determine whether the application requires review by the Underwriting Committee prior to issuance. If the applicant answers no to all questions of prior health issues, the policy may be issued without Underwriting Committee review.

If a claim is received for a service that generally requires a waiting period on a policy that was issued without being reviewed by the Underwriting Committee, the claim is forwarded to the Underwriting Committee for review. The Underwriting Committee will generally request medical records to determine whether the insured knew of the condition prior to signing an application. If the Underwriting Committee determines that the insured made a misrepresentation on the application, the application may be rescinded and a refund of premiums, less the amount of claims paid, will be issued.

The examiners did not independently judge the merits of the misrepresentation rather the examiners reviewed whether the Underwriting Committee's decision was reasonable based upon the evidence provided.

Recommendations: None

Utilization Review

This business area was not tested during this examination. The evaluation of standards in this business area is based on review of Company responses to information requests, questions, interviews, and presentations made to the examiner. This portion of the examination is designed to assure that companies, and their designees that provide or perform utilization review services, comply with standards and criteria for the structure and operation of utilization review processes. Utilization review is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

The Company does use the services of a private accreditation entity, The American Accreditation HealthCare Commission/URAC (hereafter "URAC"). The Company has received a full accreditation for the period January 1, 2001, through January 1, 2003. The accreditation is awarded after Company written responses to 35 standards are reviewed by URAC. Field testing of the responses appears to be minimal and sampling techniques do not appear to be used. Nevertheless the examiners determined that at the very least, the preparation of the responses to the URAC questions would have a salutary impact on the Company efforts in this business area. Therefore, the examiners elected to forego review of this business area in favor of other areas viewed as more critical to this examination.

Standards normally considered in a market conduct examination of this business area include:

Standard K-1 The Company establishes and maintains a utilization review program in compliance with statutes, rules, and regulations.

Standard K-2 The Company files with the Commissioner an annual summary report of its utilization review activities.

Standard K-3 The Company provides information about its utilization review program to members in a timely manner and in compliance with statutes, rules, and regulations.

Standard K-4 The Company conducts provider related utilization review activities in a timely manner and in compliance with statutes, rules, and regulations.

Standard K-5 The Company makes utilization review decisions in a timely manner and as required by state statutes, rules, and regulations and the provisions of HIPAA.

Standard K-6 The Company provides written notice in compliance with statutes, rules, and regulations for an adverse determination.

Standard K-7 The Company makes reconsideration decisions in a timely manner and in compliance with state statutes, rules, and regulations.

Standard K-8 The Company conducts standard appeals in compliance with applicable statutes, rules, and regulations.

Standard K-9 The Company conducts expedited appeals in a timely manner and in compliance with applicable statutes, rules, and regulations.

Standard K-10 The Company conducts utilization review activities and provides for emergency services in compliance with statutes, rules, and regulations.

Standard K-11 The Company monitors the activities of the utilization review organization or entity with which the carrier contracts and ensures that the contracting organization complies with applicable statutes, rules, and regulations.

Claims Practices

The evaluation of standards in this business area is based on Company responses to information items requested by the examiner, discussions with Company staff, electronic testing of claim databases, and file sampling during the examination process. This portion of the examination is designed to provide a view of how the company treats claimants and whether that treatment is in compliance with applicable statutes, rules, and regulations.

Standard L-1 – The initial contact by the Company with the claimant is within the required time frame.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-04-03(9)(b))

Comments: Review methodology for this standard is generic, sample, and electronic. This standard derives directly from N.D. Cent. Code § 26.1-04-03(9)(b) which prohibits the "Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising

under insurance policies."

Additionally, N.D. Cent. Code § 26.1-36-37.1 states in relevant part: "After receipt of a health insurance proof of loss form, the insurer shall, within fifteen business days, pay the claim or that portion of the claim, that is not contested, deny the claim, or make an initial request for additional information."

Results: Pass

Observation: A random sample of files as noted in the following table was reviewed from the listings of those types of claims made during the examination period. Concerns tested with this standard include:

1. Whether initial contact with claimants meets required contact standards.

Random Sample Review of Claims by Type

Type	Sampled	N/A	Pass	Fail	% Pass
00-01 Closed Paid Pro	100		100	0	100%
00-01 Closed Paid Inst	100		100	0	100%
00-01 Closed No Pay Pro	100		100	0	100%
00-01 Closed No Pay Inst	100		100	0	100%
Totals	400		400		100%

Most claims are received electronically from the provider. The Company's initial contact with the claimant is either a request for further information or with the explanation of benefits (EOB) explaining the reasons for payment or denial.

Recommendations: None

Standard L-2 – Investigations are conducted in a timely manner.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-04-03(9)(b))

Comments: Review methodology for this standard is generic, sample, and electronic. This standard has a direct insurance statutory requirement.

Results: Pass

Observation: A random sample of files as noted in the following table was reviewed from the listings of those types of claims made during the examination period. Concerns tested with this standard include:

1. Whether an investigation is conducted into a claim in a timely manner.

2. Whether subsequent responses and claim handling delay notices comply with applicable statutes, rules, and regulations.

Random Sample Review of Claims by Type

Type	Sampled	N/A	Pass	Fail	% Pass
00-01 Closed Paid Pro	100		100	0	100%
00-01 Closed Paid Inst	100		100	0	100%
00-01 Closed No Pay Pro	100		100	0	100%
00-01 Closed No Pay Inst	100		100	0	100%
00-01 Litigated Claims	3*		3		100%
Totals	403		403		100%

*Three represents the total number of litigated claims closed during the period under examination.

Recommendations: None

Standard L-3 – Claims are resolved in a timely manner.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-04-03(9)(b), 26.1-36-37.1)

Comments: Review methodology for this standard is generic, sample, and electronic. This standard has a direct insurance statutory requirement. Failure to resolve claims timely can invite "bad faith" actions. In a Company setting, failure to resolve claims timely can result in a migration of providers from the network with resultant disruption of service to members. N.D. Cent. Code § 26.1-36-37.1 requires claim resolution or written explanation within 15 day of receipt of claim.

Results: Pass

Observation: A random sample of files as noted in the following table was reviewed from the listings of those types of claims made during the examination period. Concerns tested with this standard include:

1. Whether claim resolutions, i.e., liability, determinations, coverage questions, and claim payment are made in accordance with North Dakota claim requirements.

2. Whether claim handling delay notices comply with applicable statutes, rules, and regulations.

Random Sample Review of Claims by Type

Type	Sampled	N/A	Pass	Fail	% Pass
00-01 Closed Paid Pro	100	0	100	0	100%
00-01 Closed Paid Int	100	0	100	0	100%
00-01 Closed No Pay Pro	100	0	99	1	99%
00-01 Closed No Pay Int	100	0	96	4	96%
00-01 Litigated Claims	3*	0	3	0	100%
Totals	403	0	398	5	98.75%

*Three represents the total number of litigated claims closed during the period under examination.

For those samples reviewed the examiners noted only 5 instances out of 400 files reviewed where the Company had not paid, denied, or requested further information within the 15 business days required by the aforementioned statute. The examiner also noted that some of the claims not paid

within the 15 business days had been adjudicated within the 15 business days and paid during the next check run. The Company processes claims checks once per week. The days between the date approved and the date of the next check run caused the days to pay to exceed the 15-day maximum per N.D. Century Code § 26.1-36-37.1.

Recommendations: Continue to emphasize the importance to claim handling personnel of the need to resolve all claims in a timely manner. Since the majority of all claims are handled in a timely manner within the current check run system, increasing the frequency of the check runs is not recommended at this time.

Standard L-4 – The Company responds to claim correspondence in a timely manner.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-04-03(9)(b))

Comments: Review methodology for this standard is generic, sample, and electronic. This standard has a direct insurance statutory requirement.

Results: Pass

Observation: This standard was not reviewed for the purposes of this examination. Under Standard L-3, the examiners verified that the majority of all claims had been resolved within the required 15 business days.

Recommendations: None

Standard L-5 – Claim files are adequately documented.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-04-03(9))

Comments: Review methodology for this standard is generic and sample. This standard has a direct insurance statutory requirement. Without adequate documentation, the various time frames in statute and/or regulation can not be demonstrated.

Results: Pass

Observation: A random sample of files as noted in the following table was reviewed from the listings of those types of claims made during the examination period. Concerns tested with this standard include:

1. Whether the quality of the claim documentation meets North Dakota requirements.

2. Whether claim files documentation is sufficient to support or justify the ultimate claim determination.

Random Sample Review of Claims by Type

Type	Sampled	N/A	Pass	Fail	% Pass
00-01 Closed Paid Pro	100	0	99	1	99%
00-01 Closed Paid Int	100	0	100	0	100%
00-01 Closed No Pay Pro	100	0	100	0	100%
00-01 Closed No Pay Int	100	0	100	0	100%
00-01 Litigated Claims	3*	0	3	0	100%
Totals	403	0	403	0	99.75%

*Three represents the total number of litigated claims closed during the period under examination.

The examiner noted that about 98% of all claims are received from the providers electronically. Therefore, all documentation is generally maintained electronically. The examiners were trained on the Company's claims system known as the Eagle System and were given read-only access to all claims files on the Eagle System. Claims files are maintained on the Eagle System for a period of 18 months. After 18 months the files are copied to fiche and stored in a library. A hard copy of documentation maintained on fiche was made available upon request.

Recommendations: None

Standard L-6 – Claims are properly handled in accordance with policy provisions and applicable statutes, rules, and regulations.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-04-03(9), 26.1-36-37.1)

Comments: Review methodology for this standard is generic and sample. This standard has a direct insurance statutory requirement.

Results: Pass

Observation: A random sample of files as noted in the following table was reviewed from the listings of those types of claims made during the examination period. Concerns tested with this standard include:

1. Whether claim handling meets North Dakota statutes and regulations.

2. Whether coverage was checked for proper application of deductible or appropriate exclusionary language.

3. Whether appropriate disclosures are given when a claim nears the applicable statute of limitations.

Random Sample Review of Claims by Type

Type	Sampled	N/A	Pass	Fail	% Pass
00-01 Closed Paid Pro	100	0	100	0	100%
00-01 Closed Paid Int	100	0	100	0	100%
00-01 Litigated Claims	3	0	3	0	100%
Totals	203	0	203	0	100%

Recommendations: None

Standard L-7 – The Company claim forms are appropriate for the type of product.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-36-37.1; NDAC Chapter 45-06-03)

Comments: Review methodology for this standard is sample and electronic. This standard has a direct insurance statutory requirement. North Dakota requires prompt response to claim communications.

Results: N/A

Observation: This standard was deemed to be not applicable for the purposes of this examination. The majority of all claims are received from providers electronically and no claim forms are used.

Recommendations: None

Standard L-8 – Claim files are reserved in accordance with the Company's established procedures.
(NDCC §§ 26.1-02-03, 26.1-03-19.2)

Comments: Review methodology for this standard is sample and electronic. This standard has a direct insurance statutory requirement. Loss reserves must be applied in a consistent manner to avoid distortions in the Company's financial statements and in the development of its rate structures.

Results: N/A

Observation: Reserves were not reviewed for the purposes of this examination because policies are not reserved for on an individual basis.

Recommendations: None

Standard L-9 – Denied and closed without payment claims are handled in accordance with policy provisions and North Dakota law.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-04-03(9))

Comments: Review methodology for this standard is generic. This standard has a direct insurance statutory requirement.

Results: Pass

Observation: A random sample of files as noted in the following table was reviewed from the listings of those types of claims made during the examination period. Concerns tested with this standard include:

1. Whether denied and closed without payment claims are based on policy provisions and applicable North Dakota statutes and regulations.

2. Whether notices of claim denials reference specific policy provisions or exclusions.

3. Whether claimants are provided with a reasonable basis for the denial when required by statute or regulation.

Random Sample Review of Claims by Type

Type	Sampled	N/A	Pass	Fail	% Pass
00-01 Closed No Pay Professional	100	0	100	0	100%
00-01 Closed No Pay Institutional	100	0	100	0	100%
00-01 Litigated Claims	3	0	3	0	100%
Totals	203	0	100	0	100%

Recommendations: None

Standard L-10 – Canceled benefit checks reflect appropriate claim handling practices.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-04-03(9))

Comments: Review methodology for this standard is electronic and sample.

Results: Pass

Observation: The samples reviewed by the examiners were electronic files that did not contain copies of the canceled checks. The examiners reviewed and relied upon audit tests of cash disbursements that were performed by the Company's external certified public accountant and Internal Audit Department.

Recommendations: None

Standard L-11 – Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy.
(NDCC §§ 26.1-02-03, 26.1-03-19.2, 26.1-04-03(9)(e))

Comments: Review methodology for this standard is generic. This standard has a direct insurance statutory requirement.

Results: Pass

Observation: The Company was only involved in three cases of litigation during the period under examination. In one case the Company is a co-plaintiff in a class action lawsuit against the tobacco industry. In the second case, the Company was a co-defendant with Blue Cross and Blue Shield of Colorado. The case was brought by the plaintiff seeking recovery of benefits above and beyond those already paid under the terms of the subscriber's benefit plan. The Company was dismissed with no additional benefits paid to the plaintiff. In the third case, the plaintiff sued the Company to recover additional benefits beyond those already paid under the terms of the subscriber's benefit plan. The Company agreed to pay an additional amount of claims and the case was dismissed.

Recommendations: None

Standard L-12 – The Company complies with the requirements of The Newborns' and Mothers' Health Protection Act of 1996.
(NDCC §§ 26.1-02-03, 26.1-03-19.2)

Comments: Review methodology for this standard is generic. This standard has a direct insurance statutory requirement.

Results: Pass

Observation: The examiners requested that the Company describe its response to the enactment of The Newborns' and Mothers' Health Protection Act of 1996. The Company responded as follows:

> When the Health Insurance Portability and Accountability Act (HIPAA) was enacted on August 21, 1996, it initiated fundamental changes to the products and services offered by [the Company]. As part of HIPAA and included among these changes were the provisions of The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA). The NMHPA was enacted on September 26, 1996, with an effective date applying its provisions to all group health plans with plan years beginning January 1, 1998. Interim administrative rules, with an effective date for plan years beginning January 1, 1999 were adopted in October 1998.
>
> A North Dakota state statutory mandate mirroring this provision was enacted in 1997, with an effective date of August 1, 1997. It is codified at §26.1-36-09.8, N.D.C.C. (S.L. 1997, ch. 258, §1).
>
> [The Company] incorporated the requirements of the NMHPA into both its self-funded and fully insured benefit plans on anniversary beginning with August 1, 1997. The was accomplished through the initiation of two (2) corporate projects, Corporate Project 1586, a project entitled "Contract Rewrite 1997" which began on July 31, 1996, and completed April 29, 1998, as well as Corporate Project 1596, "Federal Insurance Reform Implementation." Corporate Project 1596 was opened October 1, 1996, and completed July 1, 1997. […]
>
> Through these corporate projects, benefit language was incorporated into both self-funded and fully insured benefit plans to meet the dictates of the law. The benefit plan language incorporating this mandate is located in a provision under the heading, "Maternity Services," an example of which is set forth at Section 2.9 of the [Company manual]. Similar language was incorporated into all self-funded and fully insured benefit plans on group anniversary as of August 1, 1997. Additionally, the notification required pursuant to CFR §2520.102-3(u) has been incorporated into all [Company] benefit plans, both self-funded and fully insured, as of August 1, 2001. An example of this may be located in a provision entitled, "Notice to Mothers and Newborns" as found in [the Company benefit plan].
>
> The required benefits have been rated and administered in

accordance with the federal and state mandates as of group anniversary from August 1, 1997, to the current date.

The examiners reviewed materials provided by the Company and are satisfied that the Company has complied with the requirements of this standard.

Recommendations: None

Standard L-13 – The group health plan complies with the requirements of the Mental Health Parity Act of 1996 (MHPA).
(NDCC §§ 26.1-02-03, 26.1-03-19.2)

Comments: Review methodology for this standard is generic. This standard has a direct insurance statutory requirement.

Results: Pass

Observation: The Company was asked to describe its response to the requirements of The Mental Health Parity Act of 1996. The Company responded as follows:

> As with the NMHPA, as part of HIPAA and included among these significant changes were the provisions of The Mental Health Parity Act of 1996 (MPHA). The MPHA was enacted on September 26, 1996, with an effective date applying its provisions to all group health plans with plan years beginning January 1, 1998. Interim administrative rules, with an effective date for plan years beginning January 1, 1998, were adopted in December 1997.
>
> To date, no North Dakota state statute mirroring provision has been enacted.
>
> A review of the requirements of the MPHA and its effect on [the Company] was accomplished through the initiation of two (2) corporate projects, Corporate Project 1586, a project entitled "Contract Rewrite 1997" which began on July 31, 1996, and completed April 29, 1998, as well as Corporate Project 1596, "Federal Insurance Reform Implementation." Corporate Project 1596 was opened October 1, 1996, and completed July 1, 1997.
>
> Through these corporate projects, any separate annual or lifetime limits that may have existed in any [Company] self-funded or fully insured benefit plans that may have violated the requirements of the MPHA were amended to reflect the same maximum set for other benefits available under the benefit plan. Mental health benefits have been rated and administered in accordance with this federal mandate as of group anniversary from August 1, 1997, to the current date.

The examiners reviewed materials provided by the Company and are satisfied that the Company has complied with the requirements of this standard.

Recommendations: None

Standard L-14 – The Company complies with statutes, rules, and regulations for group coverage replacements.
(NDCC §§ 26.1-02-03, 26.1-03-19.2)

Comments: Review methodology for this standard is generally by sample; however, this standard was tested by a review of the related Company policies and procedures. This standard has a direct insurance statutory requirement.

Results: Pass

Observation: N.D. Admin. Code Chapter 45-08-02, et al., provides some basic rules for group coverage replacement. The Company is required to provide an extension of benefits under certain circumstances under these rules. The examiners met with the Company's Legal Division with respect to this issue. The Company did provide reassurance of compliance with these rules.

As a general matter, the Company's group insurance application contains questions regarding previous coverage allowing the Company to determine whether the contract is replacing previous coverage. When a new group seeks coverage from the Company, a list of covered services is provided as part of the marketing material. Thus, a prospective group is able to do a comparison of coverage. Additionally, Certificates of Coverage are provided through Member Services upon request when a group is canceling its coverage with the Company. These market practices provide the examiners with enough information to assure that the Company is in compliance with this standard.

Recommendations: None

SUMMARY OF RECOMMENDATIONS

1. The Company should develop a formal Anti-fraud Plan. The Anti-fraud Plan should be reduced to writing. The Anti-fraud Plan should include, but not be limited to, a set of standards/guidelines to address the resolution of all reports of potential fraud. The Anti-fraud Plan should also establish the authority of the Fraud Committee.

2. Continue updating and maintaining the Company's database of appointed agents and agencies to correspond to the proper licensure and appointment requirements and periodically check the database for accuracy.

3. Continue to emphasize the importance to claim handling personnel of the need to resolve all claims in a timely manner. Since the majority of all claims are handled in a timely manner within the current check run system, increasing the frequency of the check runs is not recommended at this time.

CONCLUSION

An examination has been conducted of the market conduct affairs of Noridian Mutual Insurance Company for the period of January 1, 2000, through December 31, 2001.

The exam was conducted in accordance with NAIC procedures. Jeffrey L. Skaare, Market Conduct Examiner, performed this exam.

EXAMINATION REPORT SUBMISSION

The Company=s cooperation in this exam is hereby noted. This examination report is respectfully submitted to the Honorable Jim Poolman, Commissioner of Insurance, North Dakota Insurance Department.

Respectfully submitted,

_____

Jeffrey L. Skaare
Market Conduct Examiner
N.D. Insurance Department